DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/08/2011 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED B. WING 445343 NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STAYE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (X5) COMPLETION TAG DATE DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 Investigation of Complaints #26807, #27570, Disclaimer: #25428 and #26535 were completed with the The Bridge at South Pittsburg does not annual Recertification survey conducted February believe and does not admit that any 28 through March 2, 2011, at The Bridge At South deficiencies existed either before, during or Pittsburg. No deficiencies were cited in relation to after the survey. The Facility reserves all Complaints #26807, #27570 and #25428 under rights to contest the survey findings through 42 CFR Part 483, Requirements for Long Term informal dispute resolution, formal appeal Care Facilities. Federal deficiencies were cited in proceedings or any administrative or legal. relation to complaint #26535. proceedings. This plan of correction is not F 157 483.10(b)(11) NOTIFY OF CHANGES meant to establish any standard of care; SS=G (INJURY/DECLINE/ROOM, ETC) F 157 contract obligation or position and the Facility reserves all rights to raise all A facility must immediately inform the resident; possible contentions and defenses in any consult with the resident's physician; and if type of civil of criminal claim, action or known, notify the resident's legal representative proceeding. Nothing contained in this plan or an interested family member when there is an of correction should be considered as a accident involving the resident which results in walver of any potentially applicable Peer injury and has the potential for requiring physician Review, Quality Assurance or self critical intervention; a significant change in the resident's examination privilege which the Facility physical, mental, or psychosocial status (i.e., a does not waive and reserves the right to deterioration in health, mental, or psychosocial assert in any administrative, civil or criminal status in either life threatening conditions or claim, action or proceeding. The Facility clinical complications); a need to alter treatment offers its response, credible allegations of significantly (i.e., a need to discontinue an compliance and plan of correction as part of existing form of treatment due to adverse its ongoing efforts to provide quality of care consequences, or to commence a new form of to residents. treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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addressed immediately and staff re-educated. Identified

concerns will be addressed in monthly QA

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CROSS-REFERENCED TO THE APPROPRIATE ID TAG PREFIX (X5) COMPLETION DATE TAG DEFICIENCY F 278 Continued From page 7 F 278 a re-weigh of 158, resulting in a 5.39% weight loss; week 2 of July, 2010=160; week 3 of July, 2010=159; and week 1 of August, 2010=154. F 280 RIGHT TO PARTICIPATE PLANNING Interview with the MDS nurse on March 2, 2011, CARE-REVISE CP at 10:15 a.m., in the Training Room, confirmed 3/31/2011 The resident has the right, unless adjudged the resident had experienced a weight loss, not a incompetent or otherwise found to be incapacitated weight gain, and the MDS assessment was under the laws of the state, to participate in planning inaccurate. care and treatment or changes in care and treatment. C/O #26535 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 Residents affected: Residents #1, #12, and #17's care plans were PARTICIPATE PLANNING CARE-REVISE CP F 280 ŚS≒D updated to reflect their current plan of care. Resident #1's foley catheter was d/c'd. Resident The resident has the right, unless adjudged #12 was referred to social/psych services. Resident incompetent or otherwise found to be #17 was assessed for safe use of the motorized incapacitated under the laws of the State, to wheelchair participate in planning care and treatment or changes in care and treatment. Residents Potentially Affected: All residents have the potential to be affected by A comprehensive care plan must be developed this cited practice. Residents with motorized within 7 days after the completion of the wheelchairs, foley catheters and urinating on foorcomprehensive assessment; prepared by an were care planned. interdisciplinary team, that includes the attending physician, a registered nurse with responsibility Systemic measures: for the resident, and other appropriate staff in DON/Designee will review care plans in disciplines as determined by the resident's needs, coordination with the MDS schedule throughout the and, to the extent practicable, the participation of week to verify accuracy of the plan of care x4 the resident, the resident's family or the resident's weeks; bi-weekly x 4 weeks. The SDC will coach legal representative; and periodically reviewed and mentor the MDS coordinator and care plan and revised by a team of qualified persons after coordinator on concerns identified. each assessment. Monitoring changes: The SDC will report any identified areas to the DON/Designee and education provided to the MDS Coordinator/care plan coordinator for follow-up as indicated. Results will be reported in monthly QA This REQUIREMENT is not met as evidenced meeting. Based on medical record review, facility policy FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 529P11 Facility ID: TN5801

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January 19, 2011. Further review of the care plan

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		R MEDICARE & MEDICAID SERVICES ICIENCIES ECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	OMB NO	
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F 280	Continued From pa	age 10			DEFICIENCY)		<u> </u>
11	Resident #17 was : February 5, 2002, V Effects of Cerebroy	admitted to the facility on with diagnoses including Late vascular Accident, Flaccid es Mellitus, and Obesity.	F2	80			
	Medical record reviet dated February 1, 2 had short term men assistance with dec	ew of the Minimum Data Set 010, revealed the resident nory impairment, and required ision making. Continued	55		,		
1	wheelchair safety as	by discharge summary dated revealed, "Power sessment was completed rated good safety with use of	×				
ur W D cc Ti ca an as	tilizing wheelchairs a fill be assessed through the session of the	policy, Wheelchairs - Use of rized, revealed, "Residents and motorized wheelchairs ugh the MDS (Minimum arding their motor and ly operate the wheelchairs. It be assessed, ussed with the resident ty. Residents will also be elchair assessment tools notorized wheelchairs"					
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 03/08/2011 FORM APPROVED OMB NO. 0938-0391

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33-3	confirmed the resid revised to include to 483.25 PROVIDE O HIGHEST WELL B	ent's care plan had not been he safe use of the power chair. CARE/SERVICES FOR EING	F 280	F 309 PROVIDE CARE/SE HIGHEST WELL BEING	RVICES FOR	3)31 zon
	or maintain the high mental, and psychological	receive and the facility must ary care and services to attain est practicable physical, social well-being, in comprehensive assessment		Each resident must receive and the necessary care and services to highest practicable physical, ment well-being, in accordance with the assessment and plan of care. Residents affected: Resident #9 was assessed for pain evaluation.	attain or maintain t al, and psychosocia comprehensive	he I = -[]
E irr	dased on medical re- naterview, the facility in nanagement interver ne (#9) of twenty-six sculting in unresolve se.	T I		Residents potentially affected: All Residents have the potential to cited practice. Med carts and MAF licensed staff in-serviced on pain p physician notification. SDC/Design new hires on pain protocol and phy Staff will be educated that if pain is relieved by current regime, MD/NP upon assessment and new orders recalso be educated on reassessing resident symptoms.	be affected by the R'S were audited an rotocol and lee will educate all sician notification, present, and not will be notified beived. Staff will	d.
Viti Va	amin B12 Deficiency scular Dementia, In: view of the Minimum 2010, revealed the sision making skills.	itted to the facility on a diagnoses including y, Cerebral Atherosclerosis, somnia and Anxlety. Data Set dated October resident had impaired		Systemic measures: Residents with new orders for pain meteriewed throughout the week in our discussed weekly in our at risk meeting reviewed for appropriate pain medical DON/Designee will compare the MA verify MD/NP notification of pain uponursing oversight.	clinical meeting and ng. E-Kits were tions. The	
abd BID	ominal discomfort)	0, revealed, "Lortab) p.o. (by mouth) (for .D/C (discontinue) Tylenol hen Lortab available"	p ri a	Monitoring change; DON/Designee will review orders for proper documentation throughout the visik meeting x 4 weeks then monthly, ddressed immediately and staff re-edit monthly QA.	week and in the ar	***

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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L 308 C	continued From pag	ge 12	F 309					
Reviet Scan) fracture Reviet 2010, assess	REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 12 Review of the Medication Record for November 2010 revealed the resident received the Tylenol 650 mg. two times a day as crdered through November 15, 2010. Continued review of the November 2010 Medication Record revealed the resident did not receive the Lortab 2.5 mg. as ordered from November 9, thru November 15, 2010, as indicated by an "X" or by the nurse signing and circling the times as "not administered" to the resident. Continued review of the back of the Medication Record revealed no documentation why the Lortab was not administered on November 9, 10, or 11, 2010 (spaces were left blank). Continued review of the Medication Record, revealed on November 12, 13, 14, & 15th, the nurses documented "Lortab not available-Pharmacy notified" Continued review of the Medication Record for November 2010 revealed the resident received the first dose of Lortab 2.5/500 mg. on November 16, 2010 at 8:00 a.m., a delay of six days. Review of facility documentation dated November 14, 2010, at 7:45 p.m., revealed the resident sustained a fall resulting in a fracture of the right hip. Continued review of the documentation revealed the (NP) was notified and ordered an X-ray, which was completed on November 15, 2010, with a diagnosis of: "Findings strongly raise suspicion of a subcapital fracture of the right proximal femurNo acute displaced fracturesCT scan (Computerized Tomography scan) would be helpful to confirm or deny a fracture of the right subcapital region" Review of the nursing notes dated November 14, 2010, at 7:45 p.m., revealed the nurse, who							
9-2507(02-99)	Previous Versions Obsolete	Event ID: 5Z9P11	Facility ID:	2000	<u>.</u>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	Taura and		OMB N	OMB NO. 0938-03		
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no documentation to pain medication, or Doctor (MD) of the shifts until November Review of the nursing 2010, at 11:00 a.m., cont. (continues) to a (R) hip" Medical redocumentation the numedication or notified complaint(s) of pains the time of the fall) usuall shifts. Review of the hospital November 16, 2010, returned to the hospital November 16, 2010, returned to the hospital a CT scan of the right pain described by the Continued review of the dated November 16, 2 rated the pain as "th Review of the results of "Acute Impacted Rig with some 90 degrees Posterior Rotation of the Review of the Medication November 2010, reveal 2010, the NP increased mg. BID to 5/500 mg. Review of the Medication of the Medication of the NP increased mg. BID to 5/500 mg. Review of the NP increased mg. BID to 5/500 mg.	complain of (R) (right) inner edical record review revealed the nurse offered the resident notified the NP/Medical resident's pain for any of the er 16, 2010. In notes dated November 15, revealed, "Pt. (patient) c/o (complain) pain mainly in ecord revealed no nurse offered the resident pain do the NP/MD of the resident's from November 14, 2010, (at notil November 16, 2010, on all documentation dated revealed the resident all on November 16, 2010 for this, due to "increased patient as 'sharp'" The hospital documentation to the CT scan revealed the patient e worst pain ever" To the CT scan revealed the patient e worst pain ever" To the CT scan revealed the Femoral Neck Fracture of Varus Angulation and the Femoral Diaphysis" To Record dated led on November 16, if the Lortab from 2.5/500 liD, due to increased pain as after the resident's fall).	F 309					

CENTE	<u>:RS FOR MEDICARE</u>	AND HUMAN SERVICES MEDICAID SERVICES					FORM	03/08/2011 APPROVED
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F 309	Continued From page	ne 14		_	-	DEFICIENCY)		
Di Versenzo	pushed against the	wali	F 30	9				
I de Fill to	Room, confirmed the with activities of daily transfers, etc. after the confirmed on Novem had "continued to condid not offer the resided to notify the Newhich began on November and until November of March 2, 2011, at Room confirmed the Lortab 2.5/500 mg. for the facility failed to propagate the propagate the propagate that the propaga	ministrator in Training (AIT) 3:45 p.m., in the Training resident was not offered r increased pain after a fall; byide any interventions to pain; the Nurse was not notified of the e resident's increased pain;						
nu afi pri tha ha Co noi Loi hav	irses did not notify the ter the fall; and of the form to going to the hose at the Lortab 2.5/500 d not been administed on the NP of the restab 2.5 mg. was not be ordered another preview confirmed the diffed for medication of the fall of the form the diffed for medication of the fall of the fall of the fall of the fall of the diffed for medication of the fall of t	e NP of the resident's pain resident's increased pain spital for the CT scan; or mg. was not available and red as ordered. Infirmed if the nurses had seldent's pain, or that the available the NP would ain medication. Further NP was the person to be			250			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445343 NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 309 Continued From page 15 F 309 onset or increased pain, the NP was present in the facility five days a week, on call at night on alternate weekends. 483.25(d) NO CATHETER, PREVENT UTI, F 315 F 315 NO CATHETER, PREVENT UTI, 3/31/204 F 315 RESTORE BLADDER SS=D RESTORE BLADDER Based on the resident's comprehensive Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters assessment, the facility must ensure that a resident who enters the facility without an the facility without and indwelling eatheter is not a catheterized unless the resident's clinical condition indwelling catheter is not catheterized unless the demonstrates that catheterization was necessary. resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate Resident affected: treatment and services to prevent urinary tract Resident #1 foley catheter was removed. infections and to restore as much normal bladder Residents potentially affected: function as possible. All residents with foley catheters have the potential to be affected by this cited practice. Residents with foley catheters were assessed for orders and This REQUIREMENT is not met as evidenced supporting diagnoses. bv: Based on medical record review, review of the Systemic Measures: facility's Roster/Sample Matrix, observation and DON/Desginee will review physician orders interview, the facility failed to obtain a physician's throughout the week for accuracy and appropriate. order or assess for the need of an indwelling diagnoses. Licensed nurses will be educated or catheter for one resident (#1) of twenty-six the protocol for foley catheters. The Infection residents reviewed... Control nurse will review (re)admissions and current residents, who have a folcy catheter, for The findings included: appropriate documentation. Resident #1 was admitted to the facility on December 9, 2010, with a diagnosis of Alzheimer's Dementia, and was re-admitted to the Monitoring change: facility on February 17, 2011, with an additional DON/Designee will review residents with foley diagnosis of Status Post ORIF (Open Reduction catheter orders. The DON/Designee will complete Internal Fixation) Left Hip due to a fracture of the the QA audit tool for residents identified with catheters weekly x4 weeks and monthly thereafter. left hip. Results will be reviewed monthly in QA.

FORM CMS-2567(02-99) Provious Versions Obsolete

Medical record review of the Minimum Data Set dated December 15, 2010, revealed the resident

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Facility (D; TN5801

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sistance with transfers and thave an indwelling catheter, of bladder. Ity's Roster/Sample Matrix 28, 2011, revealed the facility with indwelling catheters, and have an indwelling catheter. resident on February 28, 2011, p.m., and 3:10 p.m., and on 2:25 a.m., 8:35 a.m., and 12:35 resident in bed with an present. resident on March 1, 2010, at excive with PT (physical therapy department, ent was in a wheelchair and herapy following the hip observation and interview ent had an indwelling catheter nent of urine and independent to the hip fracture.	F 315				
w of the resident's care plan late to the care plan was a care plan did not address er, and stated the resident of urine.					
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445343 STREE URG, THE TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) TAG TAG TAG TAG TAG TAG TAG TA	(X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER: 445343 STREET ADDRESS, CITY, STATE, ZIP COD 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PREFIX TAGE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) Age 16 Sistance with transfers and thave an indwelling catheter, of bladder. Ity's Roster/Sample Matrix 28, 2011, revealed the facility with indwelling catheters, and have an indwelling catheter. resident on February 28, 2011, p.m., and 3:10 p.m., and on 7:25 a.m., and 3:10 p.m., and on 7:25 a.m., and a.m., and 12:35 resident in bed with an present. resident on March 1, 2010, at arview with PT (physical therapy department, ent was in a wheelchair and herapy following the hip (observation and indevelling catheter nent of urine and independent of the hip fracture. W of the physician's orders or the indwelling catheter. w of the resident's care plan fate to the care plan was a care plan did not address er, and stated the resident to furine. W of the resident and Bladder and the Bowel and Bladder pileted December 23, 2010, gifted the sconfinent of bowel in	(X1) PROVIDENSUPPLIERCIAN IDENTIFICATION NUMBER: 445343 STREET ADDRESS, CITY, STATE, ZIP CODE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PREPRICE PREPRICE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PREPRICE PREPRICE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PREPRICE PREPRICE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PREPRICE CROSS-REFERENCE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PREPRICE PREPRICE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PREPRICE PREPRICE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TAG CROSS-REFERENCE T	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/08/2011 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING 445343 B. WING NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE DEFICIENCY F 315 Continued From page 17 catheter. Further medical record review revealed F 315 no documentation the resident had an indwelling catheter and no assessment to justify the need F 323 FREE OF ACCIDENT/HAZARDS, 3/31/2011 for an Indwelling catheter. SUPERVISION/DEVICES Interview with the Director of Nursing (DON) and The facility must ensure resident environment Administrator In Training on March 1, 2011, at remains as free from accident hazards as is possible; 10:40 a.m., on Station 1, and with the DON on and each resident received adequate supervision and March 2, 2011, at 9:20 a.m., in the Training assistance devices to prevent accidents. Room, confirmed the facility did not have a physician's order, assessment, or care plan for Residents affected: the indwelling catheter, Resident #13 was assessed and the alarm was F 323 483.25(h) FREE OF ACCIDENT replaced. Resident #17 was assessed for safe use HAZARDS/SUPERVISION/DEVICES F 323 of a motorized wheelchair. The facility must ensure that the resident Residents potentially affected: environment remains as free of accident hazards All residents have potential to be affected by this as is possible; and each resident receives cited practice. Staff were educated regarding use of adequate supervision and assistance devices to alarms and safe use of motorized wheelchairs. prevent accidents. Systemic measures: Central Supply will validate alarms are turned on throughout the week and report findings to DON/Designee. All residents using motorized wheelchairs will be assessed upon admission, This REQUIREMENT is not met as evidenced. quarterly, or PRN for the safe use of their motorized wheelchairs and assessment of alarms. Based on medical review, observation, facility policy review, and interview, the facility failed to Monitoring change: provide supervision to prevent accidents for one Central Supply will immediately correct any alarm resident (#13) with an inactivated bed alarm, and that wasn't turned on and findings reported to one resident (#17) who had not been reevaluated DON/Designee throughout the work week. for safe powerchair operation. DON/Designee will notify therapy dept when a resident uses a motorized wheelchair and an The findings included: assessment will be completed. The therapy dept will assess motorized wheelchairs on admission, quarterly and PRN. Residents whom are deemed

FORM CMS-2587(02-99) Previous Versions Obsolete

Resident #13 was admitted to the facility on

February 17, 2011, with diagnoses including

Fracture Femur, Status Post Surgery, Acute

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Facility ID: TN5801

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unsafe or alarms not on will be reported to the

DON/Designee and addressed in monthly QA

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non-ambulatory.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION AND FLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED B. WING 445343 NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH-CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE TAG TAG DEFICIENCY F 323 Continued From page 19 F 323 Review of the physical therapy discharge summary dated December 8, 2010, revealed, "...Power wheelchair safety assessment was completed and patient demonstrated good safety with use of power wheelchair...' Review of the facility's documentation dated February 17, 2011, revealed resident #17 ran over another resident's foot with the power chair, and caused a skin tear to the lower left leg of the other resident. Continued review of the facility's documents revealed no documentation resident #17 had been reevaluated for the safe use of the power chair after February 17, 2011. Review of the facility policy, Wheelchairs - Use of Non-Motorized, Motorized, revealed, "...Residents utilizing wheelchairs and motorized wheelchairs will be assessed through the MDS (Minimum, Data Set) process regarding their motor and cognitive skills to safely operate the wheelchairs. Their capability should be assessed, careplanned, and discussed with the resident and/or responsible party. Residents will also be assessed utilizing wheelchair assessment tools for motorized or non-motorized wheelchairs..." Interview with the Rehab (Rehabilitation) Services Manager on March 2, 2011, at 8:30 a.m., in the office of the Director of Nursing, confirmed residents are assessed for wheelchair safety annually, quarterly, and on a case-by-case basis as needed including after incidents. Continued interview confirmed resident #17 had not been reevaluated for the continued safe use of the power chair after the incident with the other resident.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445343 NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION TAG TAG DATE DEFICIENCY) F 323 Continued From page 20 F 323 F 325 MAINTAIN NUTRITION STATUS Interview with the Director of Nursing in the 3/31/2011 UNLESS UNAVOIDABLE director's office on March 2, 2011, at 8:35 a.m., confirmed resident #17 had not been reevaluated Based on a residents's comprehensive assessment, for the safe use of the power chair after the the facility must ensure that a resident incident. (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 483.25(i) MAINTAIN NUTRITION STATUS (2) Receives a therapeutic diet when there is F 325 UNLESS UNAVOIDABLE SS=D a nutritional problem. Based on a resident's comprehensive Residents affected: assessment, the facility must ensure that a Resident #24 has been discharged. resident -(1) Maintains acceptable parameters of nutritional Residents potentially affected: All residents have the potential to be affected by status, such as body weight and protein levels, this cited practice. 100% weights on all residents unless the resident's clinical condition have been obtained and reviewed for variances demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a Systemic measures: nutritional problem. Residents are weighed on (rc)admission x 4 weeks and thereafter monthly. Residents will be reviewed at the weekly at risk meeting and if needed interventions will be implemented. Residents with significant weight loss will be reviewed weekly x 4 This REQUIREMENT is not met as evidenced weeks or until stable. Restorative nurse review by: weights and advises the DON/designee. Based on medical record review and interview, Interventions are implemented and resident is the facility failed to ensure accurate assessment, reviewed in the weekly at risk meeting. monitoring, and notification to the physician of a significant weight loss for one resident (#24) of Monitoring Change: twenty-six residents reviewed. The DON/designee will review weight audit tool weekly X 8 weeks then monthly. Concerns will be addressed when identified and reported to the QA The findings included: committee monthly. Resident #24 was admitted to the facility on June 14, 2010, with diagnoses including Vascular Dementia and Hypertension, and was discharged

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

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F 325	Continued From pa to another facility of	age 21	F 325	DEFIC	IENCY)		 	
	Medical record revi Review dated June resident was admitt weight of 167 lbs (p meals, had chewing	tew of the Nutritional Risk 18, 2010, revealed the ted on June 14, 2010, with a counds), ate 75% (percent) of						
	chewing & swallowi exemplified by) nee	Loss and, "does have a nigh risk for Loss and, "does have a nigh problem AEB (as d for mechanical soft diet ght WNL (within normal			•		u Ağei	
F F V V (c N (n	Risk) Review/Minute Progress Notes dateCurrent wt (welgh Milk x (times)3. Trig. VeightsNut'l (incrediscontinue) weekly. Intrition Program 2 of medication) pass 2 of ay)IDT (interdiscin	ew of the Monthly/Weekly t, Weekly NAR (Nutritional at es, and Interdisciplinary ed July 8, 2010, revealed t) 160 stableSupplements: gers for review: Weekly eased) RiskRelated to: dcInterventions: Special eal/ml (calories/milllllter) med oz (ounces) Qid (four times a linary team) mfg (meeting) ble X4 wks (times 4 weeks) /"			,			
mi me 6 n Ple rec	ust report to the Physets the following on onth 7.5% or more in months or weight gases Note; If a signicorded, weekly waio	r of the Monthly/Weekly revealed, "Licensed Nurse sician weight loss that iteria: 5% or more in one in 3 months 10% or more in in that is clinically adverse. If iteria: be should be monitor for change of					2. 200 2. 200 200 200 200 200 200 200 200 200 200	
Me	dical record review	of the Monthly/Weekly						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/08/2011 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445343 NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 325 Continued From page 22 F 325 Weight Recap Sheet, Weekly NAR (nutrition at risk) Review/Minutes, and Interdisciplinary Progress Notes dated June 17, 2010, revealed the resident weighed 167 pounds and was to have weekly weights. Medical record review of the Monthly/Weekly Weight Recap Sheet, Weekly NAR Review/Minutes, and Interdisciplinary Progress Notes dated June 24, 2010, revealed "...Current wt (weight) 162.5 (down) 4 1/2. Supplements: milk x 3 (three times a day). Triggers for Review: Weekly Welghts...Related to: No straw use chin tucks...conti (continue) to monitor..." Medical record review of the Monthly/Weekly Weight Recap Sheet, Weekly NAR Review/Minutes, and Interdisciplinary Progress Notes dated July 1, 2010, revealed the resident weighed 157 lbs and was re-welghed for a weight of 158 lbs. Further review revealed, "...Current wt 158 (down) 4 1/# (pounds) 5.39% (percentage of weight loss)...Triggers for Review: Weekly Weights...Nut'l (nutritional) (increased) Risk...Interventions: 2 cal/ml (calories per millifiter) med pass 2 oz (ounces every) Qid (four times a day)...' Medical record review revealed weekly NAR and IDT meetings were stopped after the July 8, 2010, meeting and no further documentation was completed in the NAR or Interdisciplinary Progress Notes. Medical record review of the

Monthly/Weekly Weight Recap Sheet revealed

and 154 lbs week 1 of August, 2010.

the resident weighed 159 lbs week 3 of July, 2010

Medical record review of a Dietary Progress Note dated July 7, 2010, revealed, "...PO (oral or by

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/08/2011 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED B. WING 445343 NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 325 Continued From page 23 mouth) intake ~ 75% (approximately). Refuses F 325 F 514 RES RECORDS. snacks at HS (bedtime)...Admit wt (weight): 167# COMPLETE/ACCURATE, ACCESSIBLE CBW (current body weight): 162.5# (down) 4.8# x 3 31 2011 3 wks (times 3 weeks)...add milk c/ (with) each The facility must maintain clinical records on each meal to add extra calorie/ pro. (Protein). Will resident in accordance with accepted professional monitor." standards and practices that are complete; accurately documented; readily accessible; and Medical record review and interview with the systematically organized. Dietary Manager on March 2, 2011, at 9:50 a.m., and 10:25 a.m., in the Training Room, confirmed Residents affected: the facility's protocol was to weigh residents on Resident # 9, #20 were assessed by NP. admission for four consecutive weeks. Continued medical record review and interview confirmed Residents potentially affected: residents who were losing weight during the four All residents have the potential to be affected by weeks were to be weighed weekly until a stable this cited practice. Licensed nurses were educated pattern had been established. Continued medical on protocol for medication administration with record review and interview confirmed the documentation. resident had not established a stable pattern of weights when the weekly weights and NAR Systemic measures: DON/Designee will validate orders written and meetings were discontinued, Continued medical compare them to the current MAR to ensure record review and interview confirmed the medication is available and documented throughout resident was exhibiting a weight loss frend and the week. The SDC will coach and mentor nurses continued to lose weight after the weekly requiring additional training on medication meetings had been discontinued and the weight administration and documentation with written loss protocol had not been followed.

Medical record review and interview with LPN #2 (Licensed Practical Nurse) on March 2, 2011, at 10:30 a.m., in the Training Room, confirmed the resident had experienced a weight loss, the facility had failed to continue to monitor the resident's weight loss, and there was no documentation the physician had been notified of the resident's weight loss.

C/O #26535

F 514 | 483.75(I)(1) RES SS=D

RECORDS-COMPLETE/ACCURATE/ACCESSIB

F 514

FORM CMS-2567(02-99) Previous Versione Obsolete

Event ID: 5Z9P11

Facility ID: TN5801

competency completed.

The SDC will conduct med pass audit tool weekly x

notification of nurses requiring additional training

by the SDC and report concerns to the monthly QA

4 weeks then monthly x 2 months and quarterly

thereafter. The DON/Designee will recieve

Monitoring change:

committee.

If continuation sheet Page 24 of 28

DEPARTMENT OF HEALTH AND HUMAN SERVICES News 82 2 65% 4 PRINTED: 03/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445343 NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION TAG PREFIX (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 514 Continued From page 24 F 514 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident, a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT Is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record was complete for two (#9, #20) of twenty-six residents reviewed. The findings included: Resident #9 was admitted to the facility on January 15, 2010, with diagnoses including Vitamin B12 Deficiency, Cerebral Atherosclerosis, Vascular Dementia, Insomnia and Anxiety. Review of the Nurse Practitioner's (NP)orders dated November 9, 2010, revealed, "...Lortab 2.5/500 mg. (Milligrams) p.o. (by mouth) (for abdominal discomfort)...D/C (discontinue) Tylenol BID (two times a day) when Lortab available..."

Review of the Medication Record for November 2010 revealed the resident received the Tylenol 650 mg, two times a day as ordered through November 15, 2010. Continued review of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445343 B. WING NAME OF PROVIDER OR SUPPLIER 03/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIDGE AT SOUTH PITTSBURG, THE 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (XII) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 514 Continued From page 25 F 514 November 2010 Medication Record revealed the resident did not receive the Lortab 2.5 mg. as ordered from November 9, thru November 15, 2010, as indicated by an "X" or by the nurse signing and circling the times as "not administered" to the resident. Continued review of the back of the Medication Record revealed no documentation why the Lortab was not administered on November 9, 10, or 11, 2010 (spaces were left blank). Resident #20 was admitted to the facility on November 18, 2010, with diagnoses including Alcohol Induced Persisting Dementia, Psychosis, Altered Mental Status, and Vertigo. Medical record review of the physician's recapitulation orders dated November 18-30, 2010, revealed the resident was to receive Thiamine (vitamin B1) 100 mg one tablet daily. Medical record review of the November 18-30, 2010, Medication Record revealed no documentation indicating if the Thiamine was administered on November 22, 23, 24, 25, 28, 29, and 30, 2010. Interview on March 2, 2011, at 10:00 a.m., with LPN #1, at the nursing station, confirmed the Medication Record was not complete and did not indicate if the Thiamine was administered on November 22, 23, 24, 25, 28, 29, and 30, 2010.